

NEW JERSEY STATE BOARD OF MEDICAL EXAMINERS

PODIATRIC SURGERY Application for Privileges N.J.A.C. 13:35-4A.12

PODIATRIC SURGERY PROCEDURES

PRIVILEGE CRITERIA

1. Attestation (Attachment 1 - in attestation format provided)

I am demonstrating clinical experience by attesting, in Attachment 1, to the number and type of procedures in general surgery which I performed in the last two years with acceptable results for patients of all age groups, except age groups specifically excluded from my practice, **plus** through additional material below.

2. Training (Attachments 2A and, depending upon privileges requested, 2B, 2C)

I am providing, as Attachment 2A, documentary evidence of **one** of the following:

(1) Current certification in podiatric surgery granted by the American Board of Podiatric Orthopedics and Primary Podiatric Medicine or the American Board of Podiatric Surgery or any other certification entity that is demonstrated by the applicant to have standards of comparable rigor, **OR**

(2) Successful completion of an accredited residency training program in podiatric surgery.

Use of Laser (Attachment 2B):

In addition to documentation of general surgical training, for privileges for use of laser, I am providing, as **Attachment 2B**, documentary evidence of **one** of the following:

(1) Completion of a laser training program sponsored by an ACCME or AOA accredited provider of Category I CME documenting laser care, physics and clinical indications for utilization of the specific laser **and successful performance of laser procedures using the specific laser under direct clinical supervision**, or

(2) Documentation from the program director of an accredited residency training program attesting to the training in specific laser therapy during residency training.

3. Record Review/Clinical Observation (Attachment 3 - in format provided):

References - Names, addresses and specialty, residency or observation only -

Licensee Name: _____ License Number: _____

I am providing, as Attachment 3, the names, addresses and specialty of three plenary licensed physicians who will directly submit references addressing my current competence based on their personal knowledge obtained either during a residency training completed during the two years preceding the date of this application or through personal observation during the two years preceding the date of this application.

4. Log of procedures (Attachment 4A, for each privilege requested - in format provided)

I am providing, as Attachment 4A, a **separate log** listing all patients for whom, in an office setting or licensed ambulatory care facility setting during the two years preceding the date of the application, I performed each of the procedures for which I am requesting privileges. The log includes a patient number, the type of anesthesia service provided, the surgery or special procedure performed and the date(s) of service. Patient names and other identifying data are redacted.

I am maintaining **in my office** a list or other means to identify the patient, based on the number included in the log.

Within each log, I have identified any patients contained in the log who have experienced complications relating to my performance of surgery or special procedures in an office setting or licensed ambulatory care facility setting and their resulting outcomes.

As part of the application for privileges process, from the logs I am providing, at least 5 cases, **with personal identifiers redacted**, that are representative of the type of procedures for which I requested privileges will be selected and I will be asked to provide patient records (or pertinent portions), along with a completed case summary form for each. _____

DELINEATION OF PRIVILEGES

I have checked the column on the left of those privileges listed below to indicate those procedures for which I do not hold hospital privileges and for which I am requesting alternative privileges to perform these procedure(s) in the office setting. I have attached additional materials, including documentation of successful completion of additional training, as was noted above as Attachments 2B, 2C, and 3A, if I am requesting privileges for the specific procedure which requires additional training, including use of laser.

Requested Privileges

_____	I.P. sesamoidectomy of hallux with anesthesia services
_____	Bunionectomy with anesthesia services
_____	Metatarsal osteotomy/Head 2-5
_____	Metatarsal head resection
_____	MPJ/IPJ capsulotomy - see also laser
_____	Digital amputations (partial)
_____	Plantar fasciotomy/fasciectomy - see also laser

Licensee Name: _____ License Number: _____

____ Ray resection
____ Repair lacerated tendons
____ Incision & drainage, deep fascial plane infection
____ Syndactyle/desyndactyle
____ Skin grafts, dorsal
____ Excision of accessory bones
____ Osteotomies of tarsals, open/closed & wedge
____ Arthroscopic surgery (Foot & Ankle) - see also laser
____ Bone Stimulation Implant
____ Other *Please specify and provide supporting documentation on a
separate page:* ____

Use of Laser: (Generally not indicated for in-office practice.)

Each requires additional training for laser.

____ warts
____ Neoplasm
____ Biopsy
____ nail procedures

Please specify procedure(s) and laser (for each) and provide supporting documentation
on a separate page: ____

**I certify that my attestation of the number of procedures and any materials
provided incident to this form (i.e. "supporting documentation") are true and
accurate. I am aware that if any of the foregoing statements made by me or if the
materials submitted by me are willfully false, I am subject to punishment.**

Signature and printed name of Applicant

Date

Below this line for Administration Use Only

Application Tracking Record:

Initial Receipt Date of Application _____
Transmittal Date to Outsourcing Entity _____
Supplemental Information Requested _____
Supplemental Information Received _____
Outsourcing Entity Recommendation _____
Outsourcing Entity Reviewer _____
Board Committee Review Date _____
Board Disposition Date _____

Licensee Name: _____ License Number: _____